

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-043952

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

11361

STATE FILE NUMBER

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN ST. LOUIS, MISSOURI

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION

BARNES HOSPITAL

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Illinois b. COUNTY Calhoun

c. CITY OR TOWN

Batchtown

Inside Limits

Yes ☐ No ☒

d. STREET ADDRESS

(If outside, give location)

RFD 1

Reside on Farm

Yes ☒ No ☐3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

JOHN

WILLIAM

BEHRENS

4. DATE OF DEATH

Month

Day

Year

NOVEMBER

22

1962

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

7/26/1905

9. AGE (last birthday)

57

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Meppen, Ill.

12. CITIZEN OF WHAT COUNTRY

U.S.

13a. FATHER'S NAME

William Behrens

13b. MOTHER'S MAIDEN NAME

Caroline Haselhorst

14. NAME OF HUSBAND OR WIFE

Dorothy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

August Fuller, Hardin, Ill.

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARCINOMA OF LUNG WITH METASTASES TO MEDIASTINUM

AND SUPERIOR VENA CAVA

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

163x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes☐ No☐ Unknown19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from JAN. 18, 1953 to Nov. 22, 1962 and last saw her alive on NOVEMBER 22, 1962

Death occurred at 7:20 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

BARNES HOSPITAL

22c. DATE SIGNED

11/23/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

11-26-62

23c. NAME OF CEMETERY OR CREMATORY

Wilson Cemetery

23d. LOCATION (City, town, or county)

Batchtown, Ill.

24. FUNERAL DIRECTOR

ADDRESS

Albert H. Hoppe, Inc., 4700 Washington Blvd.

25. DATE RECD. BY LOCAL REG.

NOV 28 1962

26. REGISTRAR'S SIGNATURE

Neal Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300  
Rev. 4/59

1

8/20/71

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USE BLACK INK  
OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Robert M. Murray*

Licensed Embalmer No. 3749

P. O. Address St Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.